EXHIBIT "6"

EXHIBIT "6"

INDEX

Footnote 18: (BS) Nos. 575-580

Footnote 19: (BS) Nos. 525-0533

Footnote 20: (BS) Nos. 502-510

Footnote 21: (BS) Nos. 479-480

Footnote 22: (BS) Nos. 465-466

Footnote 23: (BS) Nos. 468-469

Footnote 24: (BS) Nos. 428-434

Footnote 25: (BS) Nos. 351-356, 306-313

Footnote 26: (BS) Nos. 269-0274

Footnote 29: (BS) Nos. 220 – 225

FOOTNOTE 18

{2a}

PATIENT REGISTRATION FORM

HILO MEDICAL CENTER

1190 WAIANUENUE AVE HILO, HI 96720

MED REC#: H[redacted] NAME: VANHOUTEN,EVERINE A VIP: CONF:

ACCOUNT#: H[redacted] ADMIT DATE: 11/07/12 TIME: 0518 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 32 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: ETOMITA
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 5[redacted] RELIGION: NONE

L[redacted]
PHONE HM#: (8[redacted] PHONE WK#: ([redacted]
PREFERRED LANGUAGE:

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Coker, Kyle P MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: [redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted] GUAR EMP PH #: ([redacted]
[redacted] RELATIONSHIP: PATIENT
GUAR PHONE NO: ([redacted] GUARANTOR SS#: XXX-XX-3768

	INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1	DO NOT USE Quest/HMS PO Box 3520,Honolulu,HI 96811 (808)948-6486	[redacted]		VANHOUTEN,EVERINE A
2				
3				

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

HLMRPC08 ZIP/POST

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010158377**
PCP: **Henry K. Leeloy MD**
ED Physician: **Coker, Kyle P MD**
Service Date: **11/07/12**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Urinary Infection/UTI symptoms
Time Seen by Provider: 11/07/12 06:01
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Onset: Days (1)
Severity: Moderate
Timing/Duration: Constant
Modifying Factors: improves with: Medication
Associated Symptoms: None. denies: Fever/Chills, Nausea/Vomiting

Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint	triage
	pt her for evaluation of uti
symptoms including	
	pain on urination x 1 day; pt
states pain 6/10	
	now with motrin and tylenol taken
about 2 hrs	
	ago; no acute distress; pt to room
and care	
	transferred

11/07/12 06:12
This is a 32 year old female [primary care physician-Dr. Leeloy] with no significant past medical history who presents to the ED alone via POV complaining of pain with urination. Onset x 1 day, 2000 last night. Rates pain as 6/10. Reports taking motrin and tylenol with some relief of her symptoms. Adds that "everything is sore." Denies fever, chills, nausea, vomiting, hematuria, or any other associated symptoms. (Coker,Kyle P MD)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 11/07/12 05:23)

Home Medications:

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Medication	Instructions	Recorded	Type
Nitrofurantoin Macrocrystal [Macrobid (Nitrofurantoin)100MG CAP*]	100 mg PO Q6H #14 capsule	11/07/12	Rx
None		11/07/12	History
Phenazopyridine HCl [Phenazopyridine (Pyridium)*]	200 mg PO TID PRN #12 tablet	11/07/12	Rx

Past Medical History

Past Medical History: Reports: None
Past Surgical History: Cholecystectomy, Other (breast augmentation)

- Social History

Personal History: Single
Alcohol: Reports: Occasional
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems

Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Pain, Trauma
Ears/Nose/Mouth/Throat: denies: Earache, Rhinorrhea, Sinus Pain, Sore Throat
Cardiovascular: denies: Chest Pain, Palpitations
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: denies: Nausea, Vomiting
Genitourinary: Dysuria (pain with urination). denies: Hematuria
Musculoskeletal: denies: Back Pain, Neck Pain, Joint Pain
Integumentary: denies: Pruritis, Rash, Bruising
Neurological: denies: Dizziness, Headache
Psychiatric: denies: Depression, Anxiety
Endocrine: denies: Polyuria, Polydipsia
Hematologic/Lymph: denies: Easy Bruising, Excessive Bleeding
Allergic/Immunologic: denies: Food Allergy, Drug Allergy

Physical Exam

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Normal BS. Not: Tender
Abdominal Tenderness: Not: Present
Musculoskeletal: Full ROM. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert. Not: Focal Findings
Psychiatric: Nml Age Behavior, Alert

Nursing Vital Signs:

Initial Vital Signs

Name: VANHOUTEN,EVERINE A
MR #: HM00507788
DOB: [redacted]0

Temperature	36.2 C L	11/07/12 05:24
Pulse Rate	95	11/07/12 05:24
Respiratory Rate	16	11/07/12 05:24
Blood Pressure	137/93 H	11/07/12 05:24
O2 Sat by Pulse Oximetry	100	11/07/12 05:24

- Laboratory

Result Note:

Laboratory Tests

	11/07/12 05:31	Range/Units
Urine Color	Yellow	(())
Urine Appearance	Hazy	(())
Urine pH	6.0	(5.0-7.5)
Ur Specific Gravity	>1.035 H	(1.005-1.03)
Urine Protein	100 H	(NEG) mg/dL
Urine Glucose (UA)	Negative	(NEG) mg/dL
Urine Ketones	Negative	(NEG) mg/dL
Urine Blood	Large H	(NEG)
Urine Nitrate	Negative	(NEG)
Urine Bilirubin	Negative	(NEG)
Urine Urobilinogen	1.0	(0.2-1.0) EU/dL
Ur Leukocyte Esterase	Trace H	(NEG)
Urine RBC	20-50	(0-2) /hpf
Urine WBC	10-20	(0-5) /hpf
Ur Squamous Epith Cells	Mod	(()) /lpf
Urine Bacteria	Occ H	(NONE) /hpf
Urine Mucus	Few	(()) /lpf
Ur Culture Indicated?	Reflex c/s done. H	(CSND)
Urine Total Volume	2	(()) mL

Update

- Patient Update

Status on patient:
11/07/12 06:12
Charting performed by ED scribe Sarah Bakken for Dr. Coker.

- Patient Update

Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name	Dose Route	Start	Last Admin

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Trade Name	Freq PRN Reason	Stop	Dose Admin
Nitrofurantoin Macrocrystals Macrodantin Capsule	100 mg PO ONCE ONE	11/07/12 06:09 11/07/12 06:10	
Phenazopyridine HCl Pyridium Tablet	200 mg PO ONCE ONE	11/07/12 06:08 11/07/12 06:09	

Medical Decision Making/Dispo

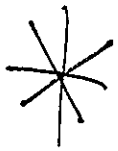
MDM Note/Critical Care Macro:

11/07/12 07:03
32-year-old female presented emergency department with dysuria and suprapubic pain since 8:00 last night. The patient has recently had sex for the first time in several months and feels that she has a developed a urinary tract infection do this. She does have a history of occasional urinary tract infections and has been some years since her last period she is not having flank pain or fevers. She denies any nausea vomiting. Otherwise she is in good health. Bowel sounds are normal. Physical exam benign. It artery studies show a urinalysis consistent with a urinary tract infection. Cultures are pending. There is not enough urine obtained to perform a CT or the patient states that she is a condom and currently has a IUD in place. She'll be started on nitrofurantoin zoster in the emergency department as an outpatient. I've asked that she follow up with her primary care physician in 3-5 days for culture results and review. She can return to the emergency department for any worsening of symptoms, no fever, intractable nausea vomiting, or other needs.
Reviewed the Following: Lab
Discussed Investigation, Dx and Tx With: Patient
Risk, Follow-up Discussed With: Patient

- Disposition

Time of Disposition: 06:49
Disposition: DC

Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - 3 to 5 Days
Ambulatory Prescriptions:
Nitrofurantoin Macrocrystal [Macrobid (Nitrofurantoin)100MG CAP*] 100 mg PO Q6H #14 capsule
Phenazopyridine HCl [Phenazopyridine (Pyridium)*] 200 mg PO TID PRN #12 tablet
PRN Reason: Pain



- Disposition

DX: (Primary DX listed 1st): Hemorrhagic cystitis
Condition: Stable
Instructions: URINARY TRACT INFECTION, General Emergency Department Discharge Instructions
Custom Instructions:
Please follow up in 3-5 days with your primary care provider. Please return to the ER if your symptoms worsen.

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Signed By: **Coker, Kyle P MD** Date/Time: **11/07/12 0705**
<Electronically signed by Kyle P Coker MD>

CC: Leeloy, Henry K. MD.

FOOTNOTE 19

(2a) PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MED REC#: HM00S07788 NAME: VANHOUTEN,EVERINE A VIP CONF

ACCOUNT#: HI0001018222 8 ADMIT DATE: 03/18/13 TIME: 1851 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: MCASTRO
FIN CLASS: QHMSA ADMIT SOURCE: CLINIC OR PHYSICIAN'
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: [redacted] RELIGION: NONE

[redacted]
PHONE HM#: [redacted] PHONE WK#: [redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Wren, Dale L MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: [redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted] GUAR EMP PH #: [redacted]
RELATIONSHIP: PATIENT
GUAR PHONE NO: [redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 Quest/HMSA PO Box 3520,Honolulu,HI 96811 (808)948-6486	[redacted]		VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:N Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed with Addenda

Patient: **VANHOUTEN,EVERINE A**
DOB: **0[redacted]**
Medical Record: **HM00507788**
Account: **HL0010182218**
PCP: **Henry K. Leeloy MD**
ED Provider: **Wren, Dale L MD**
Service Date: **03/18/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Nausea/Vomiting/Diarrhea
Time Seen by Provider: 03/18/13 19:20
Source: Patient, Parent, Hospital Records
Historian: Appears accurate
Exam Limitations: None
Onset: Hours
Severity: Moderate
Timing/Duration: Constant
Modifying Factors: improves with: Medication (Ibuprofen)
Associated Symptoms: Fever/Chills (chills only, no fever), Nausea/Vomiting, Other (diarrhea, abdominal discomfort)

Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint over the	pt reports nausea, vomiting, diarrhea last 12 hrs.

03/18/13 19:29
Patient is a 33 year old female with history of cholecystectomy who presents to the ED with her mother via POV complaining of nausea, vomiting, diarhea and abdominal discomfort. Onset earlier this morning. She is having 5/10 periumbilical abdominal "discomfort." She has been taking Ibuprofen for pain. Patient reports associated chills. She is currently afebrile. Patient denies any recent travel, dysuria or any other associated symptoms. She is not on a catchment water system. Her PCP is Dr. Leeloy. (Wren,Dale L MD)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 11/07/12 05:23)

Home Medications:

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Medication	Instructions	Recorded	Type
Nitrofurantoin Macrocrystal [Macrobid (Nitrofurantoin)100MG CAP*]	100 mg PO Q6H #14 capsule	11/07/12	Rx
None		11/07/12	History
Phenazopyridine HCl [Phenazopyridine (Pyridium)*]	200 mg PO TID PRN #12 tablet	11/07/12	Rx
Ondansetron [Zofran Odt Tablet]	4 mg PO Q6H PRN #10 tablet	03/18/13	Rx

Past Medical History

Past Medical History: Reports: None
Past Surgical History: Cholecystectomy, Other (breast augmentation)
Last Menstrual Period: Other (2/20/13)

- Social History

Personal History: Single
Alcohol: Reports: Occasional
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems

Except as noted: Reviewed and negative
Constitutional: Chills. denies: Fever
Eyes: denies: Vision Change, Discharge
Ears/Nose/Mouth/Throat: denies: Rhinorrhea, Sinus Pain, Sore Throat
Cardiovascular: denies: Chest Pain, Palpitations
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea, Vomiting, Diarrhea
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: denies: Back Pain, Neck Pain, Muscle Pain/Stiffness
Integumentary: denies: Pruritis, Rash, Bruising
Neurological: denies: Dizziness, Headache
Hematologic/Lymph: denies: Excessive Bleeding, Lymphadenopathy
Allergic/Immunologic: denies: Drug Allergy

Physical Exam

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Normal BS. Not: Tender
Abdominal Tenderness: Present, RLQ. Not: Rebound, Voluntary Guarding, Involuntary Guarding
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Age Behavior, Nml Mood/Affect, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Nursing Vital Signs:

Initial Vital Signs

Temperature	36.6 C	03/18/13 19:11
Pulse Rate	112 H	03/18/13 19:11
Respiratory Rate	16	03/18/13 19:11
Blood Pressure	135/96 H	03/18/13 19:11
O2 Sat by Pulse Oximetry	99	03/18/13 19:11

Results/Interpretations

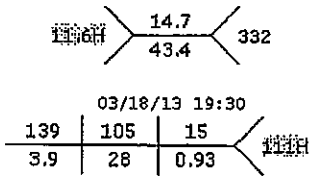
- CT Scan
** ABDOMEN AND PELVIS CT
CT Notes:
03/18/13 23:01
CONTRAST ENHANCED CT SCAN OF THE ABDOMEN AND PELVIS Technique: Computed spiral CT of the abdomen and pelvis was performed from the level of the dome of the diaphragm to the pelvic floor after the intravenous administration of 75 cc of Omnipaque 350. Oral contrast was also given. Findings: Lung bases: Clear. Liver: Normal . Gallbladder and bile ducts: Normal bile ducts. Status post cholecystectomy. Pancreas: Normal. Spleen: Normal. Aorta and retroperitoneum: Normal. Kidneys ureters and bladder: Normal, except for 3 small nonobstructing stones in the left upper renal pole calyces ranging in size from 1-5 mm. No hydronephrosis or ureteral stones. No perinephric edema. Bowel and mesentery: Normal. Appendix: Normal. Pelvis: No pelvic masses. In IUD appears well-positioned within the uterine cavity with a small amount of fluid in the cervical canal about clinical significance. Bones: Normal. Additional findings: No free fluid or air. Impression: Small nonobstructing left renal stones. No acute finding evident. Electronically signed by Scott Grosskreutz, M.D. at 10:50 PM on 18 March 2013. Board certified, American College of Radiology

- Laboratory

Result Note:

03/18/13 19:30

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]



Laboratory Tests

	03/18/13 19:30	03/18/13 20:00	Range/Units
WBC	11.6 H		(3.8-11.2) 10(9)/L
RBC	4.94		(3.9-5.2) 10(12)/L
Hgb	14.7		(11.6-15.1) g/dL
Hct	43.4		(34.1-44.2) %
MCV	87.7		(80-100) fL
MCH	29.7		(27-33) pg
MCHC	33.9		(32-36) g/dL
RDW	13.0		(11-15) %
Plt Count	332		(150-450) 10(9)/L
Differential Method	Manual		(())
Neutrophils % (Manual)	89 H		(40-70) %
Band Neutrophils %	1		(0-9) %
Lymphocytes % (Manual)	4 L		(20-45) %
Monocytes % (Manual)	6		(4-10) %
Absolute Neutrophils	10.44 H		(1.4-7.0) 10(9)/L
Absolute Lymphocytes	0.46 L		(0.7-4.5) 10(9)/L
Absolute Monocytes	0.70		(0.1-1.0) 10(9)/L
Toxic Granulation	SI		(())
Large Platelets	Present		(())
Anisocytosis	SI		(())
Sodium	139		(133-145) mmol/L
Potassium	3.9		(3.3-5.1) mmol/L
Chloride	105		(96-108) mmol/L
Carbon Dioxide	28		(21-31) mmol/L
Anion Gap	6		(4-16)
BUN	15		(8-24) mg/dL
Creatinine	0.93		(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60		(>59)
Est GFR (MDRD) Af Amer	>60		(>59)
Glucose	111 H		(70-99) mg/dL
Calcium	8.6		(8.6-10.3) mg/dL
Total Bilirubin	1.0		(0-1.2) mg/dL
AST	186 H		(0-31) U/L
ALT	176 H		(0-31) U/L
Alkaline Phosphatase	89		(34-104) U/L
Total Protein	6.8		(5.9-8.4) g/dL
Albumin	4.3		(4.0-5.1) g/dL
Globulin	2.5		(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7		(1.2-2.3)
Lipase	17		(4-58) U/L

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

HCG, Qual	Negative		(())
Urine Color		Yellow	(())
Urine Appearance		Sl hazy	(())
Urine pH		6.5	(5.0-7.5)
Ur Specific Gravity		1.020	(1.005-1.03)
Urine Protein		Trace H	(NEG) mg/dL
Urine Glucose (UA)		Negative	(NEG) mg/dL
Urine Ketones		15 H	(NEG) mg/dL
Urine Blood		Negative	(NEG)
Urine Nitrate		Negative	(NEG)
Urine Bilirubin		Negative	(NEG)
Urine Urobilinogen		4.0 H	(0.2-1.0) EU/dL
Ur Leukocyte Esterase		Negative	(NEG)
Urine RBC		0-2	(0-2) /hpf
Urine WBC		2-5	(0-5) /hpf
Ur Squamous Epith Cells		Few	(()) /lpf
Urine Bacteria		Mod H	(NONE) /hpf
Urine Mucus		Mod	(()) /lpf
Ur Culture Indicated?		Reflex c/s done. H	(CSND)

Update

- Patient Update

Status on patient:
03/18/13 19:32
Charting performed by ED scribe Kailie Shiba for Dr. Wren.

- Patient Update

Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Sodium Chloride Sodium Chloride 0.9% Bag	1000 mls @ 999 mls/hr IV .Q1H1M ONE	03/18/13 23:21 03/19/13 00:21	03/18/13 22:45 999 mls/hr
Ondansetron HCl Zofran Injection	4 mg IVP PRN PRN	03/18/13 19:17	03/18/13 20:00 4 mg

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

	NAUSEA / VOMITING		
Ondansetron HCl Zofran Odt Tablet	4 mg PO TAKEHOME ONE	03/18/13 23:24 03/18/13 23:25	03/18/13 23:25 4 mg
Morphine Sulfate Morphine Injection	5 mg IVP ONCE ONE	03/18/13 21:54 03/18/13 21:55	03/18/13 22:04 5 mg
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	03/18/13 21:54 03/18/13 21:55	03/18/13 22:04 10 mg
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	03/18/13 21:53 03/18/13 21:54	03/18/13 21:00 4 mg
Sodium Chloride Sodium Chloride 0.9% Bag	1000 mls @ 999 mls/hr IV .Q1H1M ONE	03/18/13 19:17 03/18/13 20:17	03/18/13 20:00 999 mls/hr
Pantoprazole Sodium Protonix Injection	40 mg IV ONCE ONE	03/18/13 20:00 03/18/13 20:01	03/18/13 20:00 40 mg
Diphenhydramine HCl Benadryl Injection	25 mg IV ONCE ONE	03/18/13 20:09 03/18/13 20:10	03/18/13 20:00 25 mg
Morphine Sulfate Morphine Injection	5 mg IVP ONCE ONE	03/18/13 19:34 03/18/13 19:35	03/18/13 20:05 5 mg

Medical Decision Making/Dispo

MDM Note/Critical Care Macro:

03/19/13 00:58
33 yo F with gastroenteritis with normal CT of abdomen for RLQ pain but normal appendix. Pt with elevated LFT post cholecystectomy. Alkphos and bili are not elevated. Pt reports heavy ibuprofen use but denies tylenol or alchol. No IV drug use or recent tattoo. Acute hepatitis panel sent. discussed need for close follow up with patient. LFT may be hepatitis vs viral gastroenteritis. Will call PMD tomorrow and will get LFT checked in 24-48 hours and will return for worsening symtpoms. Will avoid alchol and tylenol. Will not travel to Vegas in 2 days without recheck of LFT and see

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

PMD or in ED. Mother at bedside and aware of plan. CT of abdomen with no evidence of dilated ducts / obstruction but biliary stone is possible as well, but pt pain is RLQ making biliary stone /cholangitis less likely.

03/19/13 01:02

Reviewed the Following: Lab, Imaging, Old Charts
Discussed Investigation, Dx and Tx With: Patient, Family
Risk, Follow-up Discussed With: Patient, Family

- Disposition

Time of Disposition: 23:23
Disposition: DC

Referrals:
Leeloy,Henry K., MD [Primary Care Provider] -
Ambulatory Prescriptions:
Ondansetron [Zofran Odt Tablet] 4 mg PO Q6H PRN #10 tablet
PRN Reason: Nausea / Vomiting
Forms: Return to Work/School

- Disposition

DX: (Primary DX listed 1st): Gastroenteritis, Elevated liver enzymes
Condition: Stable
Instructions: General Emergency Department Discharge Instructions, GASTROENTERITIS
Custom Instructions:
Follow up with Dr. Leeloy for results of hepatitis screen. Avoid alcohol and Tylenol. Return for worsening symptoms. Have your liver enzymes rechecked either tomorrow afternoon or Wednesday morning. Follow up with your doctor or in the ED prior to leaving for Vegas on Wednesday.

Signed By: **Wren, Dale L MD** Date/Time: **03/19/13 0112**
<Electronically signed by Dale L Wren MD>

CC: Leeloy, Henry K. MD.

ADDENDUM

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Called patient to discuss catchment water / possible leptospirosis exposure. Calling lab to request leptospirosis send off and calld RX for doxycycline 100 mg PO BID to Longs Keauu.

Addendum Electronically Signed By: **Wren, Dale L MD** Date/Time: **03/19/13 1835**

CC: Leeloy, Henry K. MD.

FOOTNOTE 20

(2a)

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO, HI 96720

MED REC#: HM00507788 NAME: VANHOUTEN,EVERINE A VIP CONF

ACCOUNT#: HI0010182490 ADMIT DATE: 03/20/13 TIME: 1154 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: BCASTRO
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 1[redacted]ET RELIGION: NONE
[redacted]
PHONE HM#: ([redacted] PHONE WK#: ([redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Edwards, Robin MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: ([redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: 1[redacted]ET GUAR EMP PH #: [redacted]
[redacted] RELATIONSHIP: PATIENT
GUAR PHONE NO: ([redacted] GUARANTOR SS#: XXX-XX-3768

	INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1	Quest/HMSA PO Box 3520,Honolulu,HI 96811 (808)948-6486	[redacted]		VANHOUTEN,EVERINE A
2				
3				

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010182490**
PCP: **Henry K. Leeloy MD**
ED Provider: **Edwards, Robin MD**
Service Date: **03/20/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Abnormal lab value, evaluation
Stated Complaint: Abnormal lab value, evaluation
Time Seen by Provider: 03/20/13 12:16
Source: Patient, Other (family)
Historian: Appears accurate
Exam Limitations: None
Onset: Minutes
Severity: Mild
Timing/Duration: Minutes
Associated Symptoms: denies: Chest Pain, Cough, Fever/Chills, Headaches, Nausea/ Vomiting, Shortness of Breath

Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint and	paient seen on 3/18/13 for abd. pain
phoned by	vomiting, seen by Dr. Wren, patient
last night	Dr. Wren and started on antibiotics
elevated	and instructed to report to ED for
	liver function results

03/20/13 12:18

Pt is a 33 year old female with a Hx of Cholecystectomy who arrives via POV accompanied by family. Patient seen in the ED on 3/18/13 for abdominal pain and vomiting, seen by Dr. Wren. Patient phoned by Dr. Wren and started on antibiotics last night and instructed to report to ED for elevated liver function results. Pt arrives to the ED and reports mild upper abdominal tenderness at this time. She denies fever, chills, sore throat, HA, cough, CP, SOB, urinary symptoms or recent illness. Pt is currently under the care of Dr. Leeloy.

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

(Edwards,Robin MD)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 11/07/12 05:23)

Home Medications:

Medication	Instructions	Recorded	Type
Ondansetron [Zofran Odt Tablet]	4 mg PO Q6H PRN #10 tablet	03/18/13	Rx

Past Medical History

Past Medical History: Reports: None
Past Surgical History: Cholecystectomy, Other (breast augmentation)

- Family History

Significant Family History: Other (Renal Calculi)

- Social History

Personal History: Single
Alcohol: Reports: Occasional
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems

Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Trauma
Ears/Nose/Mouth/Throat: denies: Epistaxis
Cardiovascular: denies: Chest Pain
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain. denies: Nausea, Vomiting, Diarrhea
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: denies: Muscle Pain/Stiffness
Integumentary: denies: Rash
Neurological: denies: Headache
Hematologic/Lymph: denies: Lymphadenopathy
Allergic/Immunologic: denies: Drug Allergy

Physical Exam

Vital Signs Reviewed?: Yes

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Constitutional: Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Normal BS
Abdominal Tenderness: Present, RUQ
Musculoskeletal: Full ROM. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert. Not: Focal Findings
Psychiatric: Nml Age Behavior, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Nursing Vital Signs:

Initial Vital Signs

Temperature	37.3 C	03/20/13 12:08
Pulse Rate	98	03/20/13 12:08
Respiratory Rate	21 H	03/20/13 12:08
Blood Pressure	153/111 H	03/20/13 12:08
O2 Sat by Pulse Oximetry	99	03/20/13 12:08

Results/Interpretations

- Ultrasound
** US # 1
Ultrasound Note:

03/20/13 13:36
HHSC\cneal1, Neal, Dr. Christopher - 3/20/2013 1:34:01 PM
Status post cholecystectomy. No evidence of hepatobiliary obstructive disease.
Question nonobstructive lower pole calculus left kidney 9.5 mm

- Laboratory

Result Note:

Update

- Patient Update

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Status on patient:

03/20/13 12:21

Charting performed by ED scribe Tawny Souza for Dr. Edwards.

Medical Decision Making/Dispo

MDM Note/Critical Care Macro:

03/20/13 22:07
Patient presents to the emergency department with abdominal pain. After history, physical exam, and diagnostic evaluation, the etiology for their pain is unclear. In the emergency department they received [no further pain medication.. Laboratory data showed levitation of LFT's without fever or elecated white count. Gall bladder us shows nop sign of common duct stone. By history it appears patient may have passed a common duct ston about two days ago. She has some tenderess in RUQ npow but no pain. US shows no evidenc of common duct stone. Outpatient lab today per Dr Wren shows some elevated LFT's bnut patient is not symptomatic at this time. . White blood cell count was unremarkable. On serial exam their pain improved. At this point it is unclear exactly the etiology of the pt's pain; but I think they are at low risk for significant abdominal pathology based on serial exams and our ED evaluation. Patient is advised to have a followup with their primary care physician tomorrow for a recheck and repeat abdominal exam. They were advised to return to the emergency department if significant pain, fevers, not tolerating oral food or fluid, or new complaints
Reviewed the Following: Imaging, Old Charts
Discussed Investigation, Dx and Tx With: Patient, Family
Risk, Follow-up Discussed With: Patient, Family

- Disposition

Time of Disposition: 13:40
Disposition: DC

Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - (If you get severe pain or vomiting get rechecked; You should have labs rechecked when you return from Las Vegas)

- Disposition

DX: (Primary DX listed 1st): Abdominal pain
Condition: Stable
Instructions: LOW FAT DIET, ABDOMINAL PAIN, General Emergency Department Discharge Instructions

Signed By: **Edwards, Robin MD** Date/Time: **03/20/13 2214**
<Electronically signed by Robin Edwards MD>

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

CC: Leeloy, Henry K. MD.

East Hawaii Region — Patient Order Summary — Page: 1 — Date: 03/23/13 16:12 — User: Edwards,Robin MD

HL0010182490 VANHOUTEN,EVERINE A — Location: HLED — Medical Record Number: HM00507788
33/F — Attending: — Account Number: HL0010182490
Reason: — Registration: 03/20/13

Category	Order	Status	Start	Ord Provider	Ordered By
ULTRASOUND	0320-12310525900 Us Abdomen Complete	Resulted	03/20/13 12:30	Edwards,Robin MD Order Source: Physician Order	Edwards,Robin MD

Diagnosis/Signs & Symptoms: ruq pain ?common duct stones
Prior Surgeries: Yes: cholecystectomy 2011

	Date & Time	User	Device	Event	Acknowledged
1	03/20/13 12:31	Edwards,Robin MD	HMC351595	No Signature is Necessary	NA
1	03/20/13 12:31	Edwards,Robin MD	HMC351595	Order is Entered	NA
2	03/20/13 12:31	Daemon,Background	HIE-BG06	Status changed: New: Transmitted Old: Verified	NA
3	03/20/13 12:33	ITS - Daemon,Background	HIE-CM02	Status changed: New: Logged Old: Transmitted	NA
4	03/20/13 13:08	ITS - Schultz,Mark	HIE-CM02	Status changed: New: Taken Old: Logged	NA
5	03/23/13 16:11	ITS - Daemon,Background	HIE-CM02	Status changed: New: Resulted Old: Taken	NA

RG

H L10182490
HM507788

LEE LOY, HENRY K,MD
670 PONAHAWAI ST STE 218
Hilo, HI 96720
Ph#: 808-969-2011
ORDERING PHYS: LEE LOY, HENRY K

PHY#: 10222
(808) 974-6898

VANHOUTEN,EVERINE A 75049044 33Y F 03/20/2013 ZOP 10:44

Patient Tel. #: [redacted] BD: [redacted] 3500

cc Phys:

Page: 1

W1191501 COLL: 03/20/2013 08:30 REC: 03/20/2013 08:38 PHYS: WREN, DALE (HILO MC ER)

Comp Metabolic Panel

				STAT
Sodium	140	[133-145]	mmol/L	[J]
Potassium	4.4	[3.3-5.1]	mmol/L	[J]
Chloride	105	[96-108]	mmol/L	[J]
CO2	29	[21-31]	mmol/L	[J]
Anion Gap	6	[4-16]		[J]
BUN	9	[8-24]	mg/dL	[J]
Creatinine	0.85	[0.40-1.10]	mg/dL	[J]
Glucose	81	[70-99]	mg/dL	[J]
Calcium	8.8	[8.6-10.3]	mg/dL	[J]
Total Protein	6.3	[5.9-8.4]	g/dL	[J]
Albumin	4.0	[4.0-5.1]	g/dL	[J]
Globulin	2.3	[2.0-3.6]	g/dL	[J]
A/G Ratio	1.7	[1.2-2.3]		[J]
AST (SGOT)	H 120	[0-31]	U/L	[J]
ALT (SGPT)	H 291	[0-31]	U/L	[J]
Alk Phos	H 133	[34-104]	U/L	[J]
Bilirubin, Total	0.5	[0-1.2]	mg/dL	[J]
GFR(Non-African Amer)	>60	[>59]	mL/min/1.73m2	[J]
GFR (African American)	>60	[>59]	mL/min/1.73m2	[J]

Average GFR for 30-39 yr: 107
Chronic kidney disease: <60
Kidney failure: <15
Accuracy of the GFR depends on a stable creatinine and may be overestimated in malnutrition, cachexia, and cirrhosis due to reduced muscle mass.

Leptospira, AB PENDING

[J] = Performed at CLH, Hilo Medical Center, Hilo, HI 96720

W1191507 COLL: 03/20/2013 08:30 REC: 03/20/2013 08:38 PHYS: LEE LOY, HENRY K

Hepatic Function Panel

Total Protein	6.4	[5.9-8.4]	g/dL	[J]
Albumin	4.0	[4.0-5.1]	g/dL	[J]
Globulin	2.4	[2.0-3.6]	g/dL	[J]
A/G Ratio	1.7	[1.2-2.3]		[J]
AST (SGOT)	H 118	[0-31]	U/L	[J]

75049044
Page: 1

102990269

CONTINUED

HL1018 2490
Hm 507788

LEE LOY, HENRY K,MD
670 PONAHAWAI ST STE 218
Hilo, HI 96720
Ph#: 808-969-2011
ORDERING PHYS: LEE LOY, HENRY K

PHY#: 10222
(808) 974-6898

ZOP

VANHOUTEN,EVERINE A 75049044 33Y F 03/20/2013 10:44

Patient Tel. #: [redacted] BD: [redacted] 3500

Page: 2

cc Phys:

W1191507 COLL: 03/20/2013 08:30 REC: 03/20/2013 08:38 PHYS: LEE LOY, HENRY K

Hepatic Function Panel	(CONTINUED)				
Alk Phos	H 132	[34-104]	U/L		[J]
ALT (SGPT)	H 290	[0-31]	U/L		[J]
Bilirubin, Total	0.5	[0-1.2]	mg/dL	[J]	
Bilirubin, Direct	0.1	[0-0.3]	mg/dL	[J]	
Bilirubin, Indirect	0.4	[0.3-1.1]	mg/dL	[J]	

[J] = Performed at CLH, Hilo Medical Center, Hilo, HI 96720

75049044
Page: 2

102990269

END OF REPORT

FOOTNOTE 21

AdHoc Report LABORATORY REPORT

LEE LOY, HENRY K (10222;1)
670 PONAHAWAI ST
STE 218
HILO, HI 96720
Phone:808-969-2011

HL10185379
HM507788

CLINICAL LABORATORIES OF HAWAII, LLP

91-2135 Fort Weaver Rd. #300, Ewa Beach, Hawaii 96706
Phone: (808) 677-7999

PATIENT NAME	PATIENT ID	AGE	SEX	REPORT DATE	TIME
VAN HOUTEN, EVERINE A	90245932	33Y	F	4/5/2013	4:12:47 PM
PHONE	DOB		PATIENT LOC	MPI	
8089666119	[redacted]		AOP:1	N/A	
CC Physicians:					
None Requested					

Acc#: H1255468 / Final **Collected: 4/4/2013 10:26 AM**

BATTERY/TEST NAME	FLAG	RESULT	UNIT	REF. RANGE	LOC
Ur Macro Rfx Micro,C/S					
Color		Yellow			J
Appearance		Hazy			J
Specific Gravity		1.025		1.005-1.030	J
PH		6.0		5.0-7.5	J
Protein		Negative	mg/dL	NEG	J
Glucose		Negative	mg/dL	NEG	J
Ketones	*	**Trace**	**mg/dL**	**NEG**	J
Blood		Negative		NEG	J
Bilirubin		Negative		NEG	J
Urobilinogen		0.2	EU/dL	0.2-1.0	J
Nitrite		Negative		NEG	J
Leukocyte Esterase		Negative		NEG	J
Comment:					J
Reflex microscopic and culture not indicated.					

ABNORMAL SUMMARY

Acc#: H1255468 / Final **Collected: 4/4/2013 10:26 AM**

BATTERY/TEST NAME	FLAG	RESULT	UNIT	REF. RANGE	LOC
Ur Macro Rfx Micro,C/S					
Ketones	*	Trace	mg/dL	NEG	J

NOTE: The abnormal summary is supplied as a tool for identifying abnormal results. All results must still be reviewed as some abnormal results will not be included due to their interpretative or textual nature.

TESTING LOCATIONS

Code	Location	Laboratory Director	Address
J	CLH Hilo Medical Center	Stephen Smith, MD	1190 Waianuenue Ave Hilo, HI 96720

Acc#: H1255467 / Final **Collected: 4/4/2013 11:00 AM**

BATTERY/TEST NAME	FLAG	RESULT	UNIT	REF. RANGE	LOC
Unk Fast/Serum Index					
Specimen Info					
Fasting Status:		Unknown			J
Appearance:		Clear			A1
Hepatic Function Panel					
Total Protein		6.9	g/dL	5.9-8.4	A1
Albumin		4.3	g/dL	4.0-5.1	A1
Globulin		2.6	g/dL	2.0-3.6	A1
A/G Ratio		1.7		1.2-2.3	A1
AST (SGOT)		18	U/L	0-31	A1

AdHoc Report

LABORATORY REPORT

LEE LOY, HENRY K (10222;1)
670 PONAHAWAI ST
STE 218
HILO, HI 96720
Phone:808-969-2011

HL10185379
HM507788

CLINICAL LABORATORIES OF HAWAII, LLP

91-2135 Fort Weaver Rd. #300, Ewa Beach, Hawaii 96706
Phone: (808) 671-7999

PATIENT NAME	PATIENT ID	AGE	SEX	REPORT DATE	TIME
VAN HOUTEN, EVERINE A	90245932	33Y	F	4/5/2013	4:12:47 PM
PHONE	DOB	PATIENT LOC		HOI	
[redacted]	[redacted]	AOP;1		N/A	
CC Physicians:					
None Requested					

Acc#: H1255467 / Final **Collected: 4/4/2013 11:00 AM**

Alk Phos		68	U/L	34-104	A1
ALT (SGPT)		17	U/L	0-31	A1
Bilirubin, Total		0.6	mg/dL	0-1.2	A1
Bilirubin, Direct		0.2	mg/dL	0-0.3	A1
Bilirubin, Indirect		0.4	mg/dL	0.3-1.1	A1
CBC					
Automated Bld Cnt					
WBC		7.9	10(9)/L	3.8-11.2	J
RBC		4.42	10(12)/L	3.9-5.2	J
Hemoglobin		13.1	g/dL	11.6-15.1	J
Hematocrit		39.3	%	34.1-44.2	J
MCV		88.8	fL	80-100	J
MCH		29.7	pg	27-33	J
MCHC		33.5	g/dL	32-36	J
RDW		13.1	%	11-15	J
Platelet Count	**H**	**484**	**10(9)/L**	**150-450**	**J**
Peripheral Blood Diff					
Diff Method		Auto			J
Neutrophils		61	%	40-70	J
Lymphs		31	%	20-45	J
Monocytes		6	%	4-10	J
Eosinophils		1	%	0-6	J
Basophils		1	%	0-2	J
Neutrophils, Absolute		4.90	10(9)/L	1.4-7.0	J
Lymphs, Absolute		2.40	10(9)/L	0.7-4.5	J
Monocytes, Absolute		0.50	10(9)/L	0.1-1.0	J
Eosinophils, Absolute		0.10	10(9)/L	0-0.6	J
Basophils, Absolute		0.00	10(9)/L	0-0.2	J
Acute Hepatitis Panel					
Hep B Surface Ag		Nonreactive		NR	A1
Hep B Core AB, IgM		Nonreactive		NR	A1
Hep A Ab, IgM		Nonreactive		NR	A1
Hepatitis C Antibody		Nonreactive		NR	A1

This test was developed and its performance characteristics determined by Clinical Laboratories of Hawaii, LLP. It has not been cleared or approved by the U.S. Food and Drug Administration.
The FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes. It should not be regarded as investigational or for research.
This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) as qualified to perform high complexity clinical laboratory testing.

FOOTNOTE 22

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MED REC#: HM0150788[redacted] NAME: VANHOUTEN,EVERINE A VIP: CONF:

ACCOUNT#: HE0070186875 ADMIT DATE: 04/05/13 TIME: 1550 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: BCASTRO
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: [redacted] RELIGION: NONE

PHONE HM#: [redacted] PHONE WK#: [redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Katt, Kathleen MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: [redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted] GUAR EMP PH #: [redacted]
RELATIONSHIP: PATIENT
GUAR PHONE NO: [redacted] GUARANTOR SS#: [redacted]

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 Quest/HMSA PO Box 3520,Honolulu,HI 96811 (808)948-6486	[redacted]		VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010185379**
PCP: **Henry K. Leeloy MD**
ED Provider: **Katt, Kathleen MD**
Service Date: **04/05/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Abdominal Pain
Time Seen by Provider: 04/05/13 16:14
Source: Patient, Hospital Records
Historian: Appears accurate
Exam Limitations: None
Onset: Weeks
Severity: Moderate
Timing/Duration: Constant
Associated Symptoms: Nausea/Vomiting. denies: Chest Pain, Cough, Diaphoresis, Fever/Chills, Headaches, Shortness of Breath, Syncope

Notes: (location/quality/context):
Nursing Triage Note

History of Chief Complaint had having RUQ get into vomiting pt was seen here 2 wks ago and told she elevated liever enzymes. has been and RLQ pain since then and unable to PCP until next week. +nausea. denies

04/05/13 16:20
This is a 33 year old female patient of Dr.Leeloy with no significant PMHx who was last seen in the ED by Dr.Edwards who diagnosed and discharged the patient with abdominal pain s/p to a negative abdominal US. Today the patient returns to the ED alone via POV complaining of returning right sided abdominal pain since she had her gallbladder out 2 weeks ago. The patient was told that she had elevated liver enzymes as well. The patients states that since her surgery the pain has been moderate and constant. She has also been having nausea associated with the pain. She reports that the pain "lingers," it is a constant pain that does not worsen. Yesterday the patient had lab work done which reports generally normal. The patient reports that she recently had sexual intercourse and it was extremely painful. She denies any fever, diarrhea, vomiting, cough, chest pain, shortness of breath, headache, dysuria, hematuria or any

FOOTNOTE 23

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Tender, Normal BS. Not: Right CVAT, Left CVAT
Abdominal Tenderness: Present, RUQ, RLQ, LLQ. Not: Rebound, Voluntary Guarding, Involuntary Guarding
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Age Behavior, Nml Mood/Affect, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Nursing Vital Signs:

Initial Vital Signs

Temperature	97.6 F	04/05/13 16:08
Pulse Rate	88	04/05/13 16:08
Respiratory Rate	18	04/05/13 16:08
Blood Pressure	138/98 H	04/05/13 16:08
O2 Sat by Pulse Oximetry	100	04/05/13 16:08

Results/Interpretations

- Ultrasound
** US # 1
Ultrasound Note:

04/05/13 18:10
US Pelvis report:
HHSC\dwcamacho, Camacho, David W. - 4/5/2013 6:07:51 PM
Negative. IUD in endo canal

- Laboratory

Result Note:

04/05/13 16:20

8.8	13.4	491H	
	40.1		

04/05/13 16:20

139	106	18	
4.2	27	0.81	88

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Laboratory Tests

	04/05/13 16:20	Range/Units
WBC	8.8	(3.8-11.2) 10(9)/L
RBC	4.50	(3.9-5.2) 10(12)/L
Hgb	13.4	(11.6-15.1) g/dL
Hct	40.1	(34.1-44.2) %
MCV	89.1	(80-100) fL
MCH	29.7	(27-33) pg
MCHC	33.3	(32-36) g/dL
RDW	13.2	(11-15) %
Plt Count	491 H	(150-450) 10(9)/L
ESR	9	(0-20) mm/hr
Sodium	139	(133-145) mmol/L
Potassium	4.2	(3.3-5.1) mmol/L
Chloride	106	(96-108) mmol/L
Carbon Dioxide	27	(21-31) mmol/L
Anion Gap	6	(4-16)
BUN	18	(8-24) mg/dL
Creatinine	0.81	(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60	(>59)
Est GFR (MDRD) Af Amer	>60	(>59)
Glucose	88	(70-99) mg/dL
Calcium	9.3	(8.6-10.3) mg/dL
Total Bilirubin	0.4	(0-1.2) mg/dL
AST	20	(0-31) U/L
ALT	14	(0-31) U/L
Alkaline Phosphatase	74	(34-104) U/L
C-Reactive Protein	0.9	(<8.0) mg/L
Total Protein	7.2	(5.9-8.4) g/dL
Albumin	4.5	(4.0-5.1) g/dL
Globulin	2.7	(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7	(1.2-2.3)
Lipase	45	(4-58) U/L
HCG, Qual	Negative	(())

Update

- Patient Update

Status on patient:

04/05/13 16:18

Pg 4 of 5
Physician Documentation 0405-0145

FOOTNOTE 24

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAINUENUE AVE HILO, HI 96720

MED REC#: HM00507908 NAME: VANHOUTEN,EVERINE A VIP: CONF

ACCOUNT#: HE0010189749 ADMIT DATE: 04/29/13 TIME: 2147 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: AAIWOHI1
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 1[redacted] RELIGION: NONE

HILO,HI 96720
PHONE HM#: (8[redacted] PHONE WK#: [redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Nicholes, Andrew DO

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: (8[redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: 1[redacted]ET GUAR EMP PH #: ([redacted]
RELATIONSHIP: PATIENT
GUAR PHONE NO: ([redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 Quest/HMSA PO Box 3520,Honolulu,HI 96811 (808)948-6486	[redacted]		VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010189749**
PCP: **Henry K. Leeloy MD**
ED Provider: **Nicholes, Andrew DO**
Service Date: **04/29/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Vomiting
Time Seen by Provider: 04/29/13 22:15
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Onset: Days (1)
Severity: Moderate
Associated Symptoms: Fever/Chills (chills only), Headaches, Loss of Appetite, Nausea/Vomiting. denies: Cough, Rash

Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint and HA several	Pt states she has has nausia vomiting since 3am last night. Pt reports episodes of the same thing.

04/29/13 22:04
This is a 33 year old female patient [primary care provider- Dr. Leeloy] with no significant past medical history who presents to the ED with family via POV complaining of nausea, vomiting, and headache. Onset 0300 yesterday morning. Reports that she has been unable to keep any food down all day, and adds that she has been having abdominal pains for the last month and a half. She reports chills and a sore throat, but denies any abdominal pain this evening, fever, rash, rhinorrhea, earache, dysuria, hematuria, diarrhea, constipation, hematochezia, or any other associated symptoms. The patient did present to her PCP regarding her symptoms, and an ultrasound was performed that was reportedly "normal." She adds that her current pain feels very similar to her past gall stone pain. (Nicholes,Andrew)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 04/05/13 16:11)

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Home Medications:

Medication	Instructions	Recorded	Type
Ondansetron [Zofran ODT Tab]	1 - 2 tab PO Q4HP PRN #20 tab	04/05/13	Rx
Tramadol HCl [Ultram Tablet]	50 mg PO Q4HP PRN #20 tablet	04/05/13	Rx

Past Medical History

Past Medical History: Reports: None
Past Surgical History: Cholecystectomy

- Social History

Personal History: Single, Other (presents alone to the ED)
Alcohol: Reports: Never
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems

Except as noted: Reviewed and negative
Constitutional: Chills, Malaise. denies: Fever
Eyes: denies: Pain, Trauma
Ears/Nose/Mouth/Throat: Sore Throat. denies: Earache, Rhinorrhea, Sinus Pain
Cardiovascular: denies: Chest Pain
Respiratory: denies: Dyspnea
Gastrointestinal: Nausea, Vomiting. denies: Abdominal Pain (although she has had abdominal pain, she denies any here in the ED), Diarrhea, Constipation, Hematochezia
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: denies: Back Pain, Neck Pain, Joint Pain
Integumentary: denies: Rash
Neurological: Headache. denies: Dizziness, Syncope
Psychiatric: denies: Depression, Anxiety
Endocrine: denies: Polyuria, Polydipsia
Hematologic/Lymph: denies: Easy Bruising, Excessive Bleeding
Allergic/Immunologic: denies: Food Allergy, Drug Allergy

Physical Exam

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Tender, Normal BS
Abdominal Tenderness: Present (diffusely). Not: Rebound, Voluntary Guarding,

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Involuntary Guarding
Musculoskeletal: Full ROM. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert. Not: Focal Findings
Psychiatric: Nml Age Behavior, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Nursing Vital Signs:

Initial Vital Signs

Temperature	36.4 C	04/29/13 21:55
Pulse Rate	87	04/29/13 21:55
Respiratory Rate	19	04/29/13 21:55
Blood Pressure	131/90 H	04/29/13 21:55
O2 Sat by Pulse Oximetry	98	04/29/13 21:55

- Laboratory

Result Note:

04/29/13 22:20

11.8H	14.1	432
	42.4	

04/29/13 22:20

134	105	15	88
4.2	23	0.83	

Laboratory Tests

	04/29/13 22:20	04/29/13 22:38	Range/Units
WBC	11.8 H		(3.8-11.2) 10(9)/L
RBC	4.80		(3.9-5.2) 10(12)/L
Hgb	14.1		(11.6-15.1) g/dL
Hct	42.4		(34.1-44.2) %
MCV	88.3		(80-100) fL
MCH	29.5		(27-33) pg
MCHC	33.4		(32-36) g/dL
RDW	12.9		(11-15) %
Plt Count	432		(150-450) 10(9)/L
Neut %	76 H		(40-70) %
Lymph %	21		(20-45) %
Mono %	3 L		(4-10) %
Eos %	0		(0-6) %
Baso %	0		(0-2) %

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Differential Method	Auto		(())
Absolute Neutrophils	8.90 H		(1.4-7.0) 10(9)/L
Absolute Lymphocytes	2.50		(0.7-4.5) 10(9)/L
Absolute Monocytes	0.40		(0.1-1.0) 10(9)/L
Absolute Eosinophils	0		(0-0.6) 10(9)/L
Absolute Basophils	0		(0-0.2) 10(9)/L
Sodium	134		(133-145) mmol/L
Potassium	4.2		(3.3-5.1) mmol/L
Chloride	105		(96-108) mmol/L
Carbon Dioxide	23		(21-31) mmol/L
Anion Gap	6		(4-16)
BUN	15		(8-24) mg/dL
Creatinine	0.83		(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60		(>59)
Est GFR (MDRD) Af Amer	>60		(>59)
Glucose	88		(70-99) mg/dL
Calcium	9.3		(8.6-10.3) mg/dL
Total Bilirubin	0.8		(0-1.2) mg/dL
AST	17		(0-31) U/L
ALT	22		(0-31) U/L
Alkaline Phosphatase	68		(34-104) U/L
Total Protein	7.3		(5.9-8.4) g/dL
Albumin	4.6		(4.0-5.1) g/dL
Globulin	2.7		(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7		(1.2-2.3)
Lipase	8		(4-58) U/L
Urine Color		Yellow	(())
Urine Appearance		Hazy	(())
Urine pH		6.0	(5.0-7.5)
Ur Specific Gravity		1.025	(1.005-1.03)
Urine Protein		Negative	(NEG) mg/dL
Urine Glucose (UA)		Negative	(NEG) mg/dL
Urine Ketones		40 H	(NEG) mg/dL
Urine Blood		Negative	(NEG)
Urine Nitrate		Negative	(NEG)
Urine Bilirubin		Negative	(NEG)
Urine Urobilinogen		0.2	(0.2-1.0) EU/dL
Ur Leukocyte Esterase		Negative	(NEG)
Urine RBC		0	(0-2) /hpf
Urine WBC		0	(0-5) /hpf
Ur Squamous Epith Cells		Few	(()) /lpf
Urine Bacteria		Occ H	(NONE) /hpf
Urine Mucus		Few	(()) /lpf
Ur Culture Indicated?		Reflex c/s not done.	(CSND)
Urine HCG, Qual		Negative	(())

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Update

- Patient Update

Status on patient:
04/29/13 22:04
Charting performed by ED scribe Sarah Bakken for Dr. Nicholes.

04/29/13 23:27
Patient complaining of headache- given Toradol, Reglan, and Benadryl.

- Patient Update

Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Pantoprazole Sodium Protonix Tablet	40 mg PO ONCE ONE	04/29/13 23:48 04/29/13 23:49	
Diphenhydramine HCl Benadryl Injection	50 mg IV ONCE ONE	04/29/13 23:42 04/29/13 23:43	04/29/13 23:46 50 mg
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	04/29/13 23:26 04/29/13 23:27	04/29/13 23:28 10 mg
Sodium Chloride Sodium Chloride 0.9% Bag	1000 mls @ 999 mls/hr IV .Q1H1M ONE	04/29/13 22:20 04/29/13 23:20	04/29/13 22:33 999 mls/hr
Ketorolac Tromethamine Toradol Injection	30 mg IV ONCE ONE	04/29/13 22:41 04/29/13 22:42	04/29/13 22:44 30 mg
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	04/29/13 22:20 04/29/13 22:21	04/29/13 22:33 4 mg

Medical Decision Making/Dispo

MDM Note/Critical Care Macro:

04/29/13 23:33
After history, physical exam, and diagnostic evaluation, the etiology for the patient's vomiting is unclear. On serial exam the abdomen is soft without peritoneal signs. Laboratory data was non-diagnostic. After treatment vomiting resolved and hydration was satisfactory. I think the pt is at low risk for significant abdominal pathology based on serial exams and ED evaluation. Pt is advised to have a follow-up with the primary care physician. They were advised to return to the emergency department if significant pain, fevers, not tolerating oral food or fluid, bloody vomit or stools or any new complaints. Instructed to take prilosec daily.

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

04/29/13 23:47

04/29/13 23:55

Discussed Investigation, Dx and Tx With: Patient, Family
Risk, Follow-up Discussed With: Patient, Family

- Disposition

Time of Disposition: 23:55
Disposition: DC

Referrals:
Leeloy,Henry K., MD [Primary Care Provider] -

- Disposition

DX: (Primary DX listed 1st): Vomiting, Headache
Condition: Stable
Instructions: Acute Headache (ED), VOMITING, General Emergency Department Discharge Instructions
Custom Instructions:
Please be sure to follow up this week with your primary care provider, and return to the ER if your symptoms worsen.

Signed By: **Nicholes, Andrew DO** Date/Time: **04/29/13 2355**
<Electronically signed by Andrew Nicholes DO>

CC: Leeloy, Henry K. MD.

FOOTNOTE 25

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010202112**
PCP: **Henry K. Leeloy MD**
ED Provider: **FitzGerald,Judith DO**
Service Date: **07/09/13**

History of Present Illness

Nursing Note: Agreed With
Source: Patient, Parent
Historian: Appears accurate
Exam Limitations: None
Onset: Hours
Severity: Moderate
Timing/Duration: Hours
Associated Symptoms: Nausea/Vomiting. denies: Fever/Chills

Chief Complaint: Abdominal Pain
Time Seen by Provider: 07/09/13 02:50
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint pt here for evaluation of n/v and rlq abdominal pain that has been present x 3 months wih recent visit to ed; pt states difficulty getting in to referral for possible cholysysectomy; noted distress

07/09/13 02:50
Patient was seen here on July 5 for same. She had labs showing slight elevation of the LFTs, a CT and ultrasound demonstrating likely hemangiomas in the liver. Patient tried to follow up with Dr LeeLoy as requested but was unable to get an appointment. She is status post chole and saw Dr Jahraus with that surgery but has not seen GI since her surgery. She reports intermittant RUQ abdominal pain since the surgery worse the past several days, tonight accompanied with nausea and vomiting. (FitzGerald,Judith)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 07/09/13 02:23)

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Home Medications:

Medication	Instructions	Recorded	Type
NK [NK]		07/09/13	History

Past Medical History

Past Medical History: Reports: Other (migraines). Denies: Asthma, DM, HTN
Past Surgical History: Cholecystectomy, Other (breast augmentation)
- Family History

Significant Family History: Cancer
- Social History

Personal History: Employed
Smoking Status: Never Smoker
Review of Systems

Except as noted: Reviewed and negative
Physical Exam

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Distress (moderate), Appears Stated Age
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: Nodes
Cardiovascular: Regular Rate & Rhythm. No: Murmur, Rub, Gallop
Respiratory: BS Normal/Equal Bilat. No: Wheezing, Crackles, Rhonchi
Gastrointestinal: Soft, Tender, Normal BS
Abdominal Tenderness: Present, RUQ. Not: Rebound, Voluntary Guarding, Involuntary Guarding, Referred Pain
Musculoskeletal: Full ROM, Supple Neck
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3
Psychiatric: Nml Age Behavior, Nml Mood/Affect
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Nursing Vital Signs:

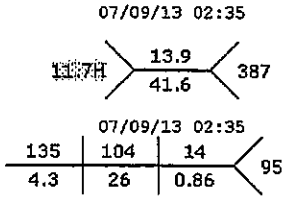
Initial Vital Signs

Temperature	37.0 C	07/09/13 02:24
Pulse Rate	112 H	07/09/13 02:24
Respiratory Rate	20	07/09/13 02:24
Blood Pressure	149/101 H	07/09/13 02:24
O2 Sat by Pulse Oximetry	100	07/09/13 02:24

Results/Interpretations
- Laboratory

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Result Note:



Laboratory Tests

	07/09/13 02:35	Range/Units
WBC	11.7 H	(3.8-11.2) 10(9)/L
RBC	4.70	(3.9-5.2) 10(12)/L
Hgb	13.9	(11.6-15.1) g/dL
Hct	41.6	(34.1-44.2) %
MCV	88.5	(80-100) fL
MCH	29.5	(27-33) pg
MCHC	33.3	(32-36) g/dL
RDW	14.0	(11-15) %
Plt Count	387	(150-450) 10(9)/L
Neut %	53	(40-70) %
Lymph %	35	(20-45) %
Mono %	6	(4-10) %
Eos %	6	(0-6) %
Baso %	0	(0-2) %
Differential Method	Auto	(())
Absolute Neutrophils	6.20	(1.4-7.0) 10(9)/L
Absolute Lymphocytes	4.10	(0.7-4.5) 10(9)/L
Absolute Monocytes	0.70	(0.1-1.0) 10(9)/L
Absolute Eosinophils	0.70 H	(0-0.6) 10(9)/L
Absolute Basophils	0	(0-0.2) 10(9)/L
Sodium	135	(133-145) mmol/L
Potassium	4.3	(3.3-5.1) mmol/L
Chloride	104	(96-108) mmol/L
Carbon Dioxide	26	(21-31) mmol/L
Anion Gap	5	(4-16)
BUN	14	(8-24) mg/dL
Creatinine	0.86	(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60	(>59)
Est GFR (MDRD) Af Amer	>60	(>59)
Glucose	95	(70-99) mg/dL
Calcium	9.0	(8.6-10.3) mg/dL
Total Bilirubin	1.0	(0-1.2) mg/dL
AST	142 H	(0-31) U/L
ALT	120 H	(0-31) U/L
Alkaline Phosphatase	97	(34-104) U/L
Total Protein	7.2	(5.9-8.4) g/dL

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Albumin	4.2	(4.0-5.1) g/dL
Globulin	3.0	(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.4	(1.2-2.3)
Lipase	70 H	(4-58) U/L
HCG, Qual	Negative	(())

07/09/13 03:35

Laboratory Tests

	07/05/13 08:15
WBC	10.6
Hgb	14.1
Hct	41.3
Plt Count	420
Sodium	138
Potassium	4.0
Chloride	105
Carbon Dioxide	27
BUN	16
Creatinine	1.00
Glucose	75
Total Bilirubin	0.8
AST	180 H
ALT	112 H
Alkaline Phosphatase	100
Lipase	21

(FitzGerald,Judith)

Update
- Patient Update

Visit Medications:

ED Visit Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Sodium Chloride Sodium Chloride 0.9% Bag	1,000 mls @ 100 mls/hr IV .Q10H ONE	07/09/13 02:52 07/09/13 12:51	07/09/13 03:02 100 mls/hr Administration

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Diphenhydramine HCl Benadryl Injection	25 mg IV	07/09/13 02:52 07/09/13 02:53	07/09/13 03:02 25 mg

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

	ONCE ONE		Administration
Ketorolac Tromethamine Toradol Injection	30 mg IV ONCE ONE	07/09/13 02:52 07/09/13 02:53	07/09/13 03:02 30 mg Administration
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	07/09/13 02:52 07/09/13 02:53	07/09/13 03:02 10 mg Administration
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	07/09/13 02:52 07/09/13 02:53	07/09/13 03:02 4 mg Administration

Medical Decision Making/Dispo

Reviewed the Following: Lab, Old Charts
Discussed Investigation, Dx and Tx With: Patient, Family
Risk, Follow-up Discussed With: Patient, Family
- Disposition

Time of Disposition: 04:38
Disposition: DC

MDM Note/Critical Care Macro:
07/09/13 03:36
Patient was seen on 7/5/13 for same. She had CT and abdominal ultrasound showing hemangiomas in the liver; she is s/p cholecystectomy. Patient admits to intermittant abdominal pain RUQ since the surgery. She admits to increasing pain with nausea, vomiting for several days. She woke from sleep tonight with emesis and pain. No other family members are ill. She is using the percocet from her previous ED visit with limited relief. She admits to RUQ pain radiating the the back. Exam is notable for tearful female with clear lungs, soft abdomen with RUQ tenderness with no rebound, no guarding, no referred pain. Pain is managed with toradol, benadryl, reglan and zofran IV. CBC and chemistries are notable for white count of 11.7 with no bandemia, chemistries with good renal function and elevation of the AST, ALT and lipase consistent with previous recent visit. Urine is negative.

07/09/13 04:38
Patient is pain free and sleeping quietly. She is discharged to PMD and GI followup as needed. (FitzGerald,Judith)

Referrals:
Leeloy,Henry K., MD [Primary Care Provider] -
Forms: Return to Work/School
- Disposition

DX: (Primary DX listed 1st):
abdominal pain, Abdominal pain
Condition: Good

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Instructions: General Emergency Department Discharge Instructions
Custom Instructions:
Follow up with Dr Jahraus this week for recheck.

Signed By: **FitzGerald, Judith DO** Date/Time: **07/09/13 0552**
<Electronically signed by Judith FitzGerald DO>

CC: Leeloy, Henry K. MD.

(2nd)

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO, HI 96720

MED REC#: HK00507788 NAME: VANHOUTEN,EVERINE A VIP: CONF:

ACCOUNT#: HE00102033[redacted] ADMIT DATE: 07/16/13 TIME: 1216 DISCHG DATE:
BIRTHDATE: 0[redacted] SERV/LOC: HILED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: JKAHEE
FIN CLASS: HMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 1[redacted] RELIGION: NONE

[redacted]
PHONE HM#: ([redacted] PHONE WK#: ([redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Calvert, Douglas DO

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: ([redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted]TREET GUAR EMP PH #: ([redacted]
K[redacted] RELATIONSHIP: PATIENT
GUAR PHONE NO: ([redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 HMSA PO Box 32700,Honolulu,HI 96803 (800)790-4672	[redacted]	690	VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 07/05/13 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010203364**
PCP: **Henry K. Leeloy MD**
ED Provider: **Calvert, Douglas DO**
Service Date: **07/16/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Abdominal Pain
Time Seen by Provider: 07/16/13 13:05
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint pt arrives via POV with c\o abdominal pain. pt has had abdominal pain since March, and was seen here July 5th and this past tuesday for the pain. Right upper and lower quadrant pain. pt has CT and US and was told she has "spots on her liver" and has an appointment to see MD Hartman on Monday. however she was at work today, she works in nursing admin here at HMC when she pain worsened and became very sharp. pt is tearful, and guarding.

07/16/13 13:07
This is a 33 year old female with a PMHx of migraines who presents to the ED alone via POV complaining of abdominal pain. Onset March 2013. Pain has been intermittent since March, and the patient was seen in the ED several times since then for abdominal pain. Her CT and US from 7/5/13 showed some possible hemangiomas of her liver. Patient states her pain has been worsening and has been occurring more frequently. Pain is currently severe, sharp, stabbing, and radiates to her back. Pain is prominent in the epigastric region and RUQ. Also ntoes some intermittent nausea and vomiting. She states she is scheduled to have an MRI this Friday. Patient also reports a sensation of "tightness" to her bilateral legs behind her knees that began while lying here in the emergency department. Denies any fever, diarrhea, constipation, rash or any other

associated symptoms at this time. Patient is scheduled to see Dr. Hartman this upcoming Monday.
Onset: Chronic
Severity: Moderate
Timing/Duration: Intermittent
Modifying Factors: Improves with: Other (none)
Associated Symptoms: Nausea/Vomiting. denies: Chest Pain, Fever/Chills, Shortness of Breath
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 07/09/13 02:23)

Home Medications:

Medication	Instructions	Recorded	Type
Ondansetron [Zofran Odt(Ondansetron)4Mg *]	4 mg SL Q6HP PRN #10 tablet	07/09/13	Rx

Past Medical History

Past Medical History: Reports: Other (migraines). Denies: Asthma, DM, HTN
- Social History

Smoking Status: Never Smoker
Review of Systems

Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Photophobia, Vision Change
Ears/Nose/Mouth/Throat: denies: Earache, Rhinorrhea
Cardiovascular: denies: Chest Pain, Palpitations
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea, Vomiting. denies: Diarrhea, Constipation
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: denies: Back Pain, Neck Pain
Integumentary: denies: Pruritis, Rash
Neurological: denies: Dizziness, Headache
Allergic/Immunologic: denies: Drug Allergy
Physical Exam

Nursing Vital Signs:

Initial Vital Signs

Temperature	36.2 C L	07/16/13 12:20
Pulse Rate	120 H	07/16/13 12:20
Respiratory Rate	20	07/16/13 12:20
Blood Pressure	154/110 H	07/16/13 12:20

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

O2 Sat by Pulse Oximetry	98	07/16/13 12:20

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
Eyes: PERRL, EOMI. No: Scleral icterus, Pale conjunctiva
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur, Rub, Gallop
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress, Wheezing, Crackles, Rhonchi
Gastrointestinal: Soft, Normal BS. Not: Tender, Hepatomegaly, Splenomegaly
Abdominal Tenderness: Not: Present
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Age Behavior, Nml Mood/Affect, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Purpura, Petechia, Lymphadenopathy
Results/Interpretations
- Laboratory

Result Note:

07/16/13 12:35

12.4H	14.6 / 43.6	436

07/16/13 12:35

137	102	16	87
4.1	26	0.86	

Laboratory Tests

	07/16/13 12:35	07/16/13 13:49	07/16/13 16:21	Range/Units
WBC	12.4 H			(3.8-11.2) 10(9)/L
RBC	4.90			(3.9-5.2) 10(12)/L
Hgb	14.6			(11.6-15.1) g/dL
Hct	43.6			(34.1-44.2) %
MCV	89.1			(80-100) fL
MCH	29.8			(27-33) pg
MCHC	33.4			(32-36) g/dL
RDW	14.3			(11-15) %
Plt Count	436			(150-450) 10(9)/L

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Neut %	49			(40-70) %
Lymph %	39			(20-45) %
Mono %	8			(4-10) %
Eos %	3			(0-6) %
Baso %	1			(0-2) %
Differential Method	Auto			(())
Absolute Neutrophils	6.10			(1.4-7.0) 10(9)/L
Absolute Lymphocytes	4.90 H			(0.7-4.5) 10(9)/L
Absolute Monocytes	0.90			(0.1-1.0) 10(9)/L
Absolute Eosinophils	0.40			(0-0.6) 10(9)/L
Absolute Basophils	0.10			(0-0.2) 10(9)/L
Sodium	137			(133-145) mmol/L
Potassium	4.1			(3.3-5.1) mmol/L
Chloride	102			(96-108) mmol/L
Carbon Dioxide	26			(21-31) mmol/L
Anion Gap	9			(4-16)
BUN	16			(8-24) mg/dL
Creatinine	0.86			(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60			(>59)
Est GFR (MDRD) Af Amer	>60			(>59)
Glucose	87			(70-99) mg/dL
Calcium	10.0			(8.6-10.3) mg/dL
Total Bilirubin	0.5			(0-1.2) mg/dL
AST	24			(0-31) U/L
ALT	53 H			(0-31) U/L
Alkaline Phosphatase	90			(34-104) U/L
Total Protein	7.8			(5.9-8.4) g/dL
Albumin	4.9			(4.0-5.1) g/dL
Globulin	2.9			(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7			(1.2-2.3)
Amylase	66			(28-100) U/L

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Lipase	33			(4-58) U/L
HCG, Qual	Negative			(())
Urine Color		Yellow	Yellow	(())
Urine Appearance		Clear	Sl hazy	(())
Urine pH		6.0	6.5	(5.0-7.5)
Ur Specific Gravity		<1.005 L	1.015	(1.005-1.03)
Urine Protein		Negative	Negative	(NEG) mg/dL
Urine Glucose (UA)		Negative	Negative	(NEG) mg/dL
Urine Ketones		Negative	Negative	(NEG) mg/dL
Urine Blood		Negative	Negative	(NEG)
Urine Nitrate		Negative	Negative	(NEG)
Urine Bilirubin		Negative	Negative	(NEG)
Urine Urobilinogen		0.2	0.2	(0.2-1.0) EU/dL
Ur Leukocyte Esterase		Mod H	Negative	(NEG)
Urine RBC		0-2	0-2	(0-2) /hpf
Urine WBC		5-10	2-5	(0-5) /hpf
Ur Squamous Epith Cells		Mod		(()) /lpf
Amorphous Crystals			Occ	(()) /lpf
Urine Bacteria		Few H	None	(NONE) /hpf
Urine Mucus		Mod	Few	(()) /lpf
Ur Culture Indicated?		Reflex c/s done. H	Reflex c/s not done.	(CSND)

- CT Scan
** Abdomen/Pelvis CT from 7/5/13
CT Notes:
07/16/13 13:18
Abdomen/Pelvis CT from 7/5/13 read by radiologist Dr. Harvey Nakamura:
IMPRESSION:
1. Cholecystectomy.
2. Three enhancing foci in the liver on the arterial phase, possibly hemangiomas.
Recommendation: Ultrasound examination for further evaluation.
3. Several nonobstructing left renal stones.
4. Intrauterine device in the uterus.

- Ultrasound
** Abdomen US from 7/5/13
Ultrasound Note:
07/16/13 13:18
Abdomen US from 7/5/13 read by radiologist Dr. Harvey Nakamura:
IMPRESSION:
Two ill-defined heterogeneous masses demonstrated in the left lobe of the liver consistent with the CT scan findings. These may be hemangiomas.
Recommendation: Follow-up CT or ultrasound scans or an MRI scan for further evaluation.

- Magnetic Resonance Imaging

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

** Abdomen MRI
MRI Notes:
07/16/13 16:51
HHSC\cneal1, Neal, Christopher - 7/16/2013 4:29:49 PM
Subcutaneous emphysema in the webspace between the first and second ray and the palm.
Update
- Patient Update

Status on patient:
07/16/13 13:06
Charting performed by ED scribe Grady Sullivan for Dr. Calvert.
Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Sodium Chloride Sodium Chloride 0.9% Bag	1,000 mls @ 100 mls/hr IV .Q10H ONE	07/16/13 12:39 07/16/13 22:38	07/16/13 12:39 100 mls/hr Administration
Ketorolac Tromethamine Toradol Injection	30 mg IV ONCE ONE	07/16/13 14:51 07/16/13 14:52	07/16/13 14:10 30 mg Administration
Lorazepam Ativan Injection	0.5 mg IV ONCE ONE	07/16/13 13:29 07/16/13 13:30	07/16/13 13:50 0.5 mg Administration
Morphine Sulfate Morphine Injection	5 mg IVP ONCE ONE	07/16/13 13:29 07/16/13 13:30	07/16/13 13:48 5 mg Administration
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	07/16/13 12:47 07/16/13 12:48	07/16/13 12:51 4 mg Administration
Ondansetron HCl Zofran Odt Tablet	4 mg PO ONCE ONE	07/16/13 13:29 07/16/13 13:30	07/16/13 17:38 Not Given

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Medical Decision Making/Dispo

MDM Note/Critical Care Macro:
07/16/13 13:29
33-year-old female to emergency Department with complaint of several month history of right upper quadrant abdominal pain. Patient reports that she does have pain medicines prescribed, she rarely takes them. She reports the pain is sharp. Reports ongoing nausea without vomiting. Patient does have an appointment with gastroenterology scheduled for 6 days from now. She also has an MRI scheduled for 3 days from now. Patient has had numerous visits to the emergency department over the last several months with similar complaints. Hepatitis screen negative. CBC has been normal. CMP demonstrated intermittent elevation of liver enzymes with normal bilirubin. Patient had a urinary tract infection on July was initiated on Macrobid, however a urine culture demonstrated mixed flora.

Patient has had numerous imaging studies. On March 18 of this year CT scan demonstrated small nonobstructing left renal stones no other acute findings. Ultrasound performed 2 days later demonstrated status post cholecystectomy without evidence of hepatobiliary obstructive disease. Pelvic ultrasound performed on April 5 was normal. On July 5 patient had a repeat CT scan of the abdomen and pelvis which demonstrated cholecystectomy and 3 enhancing foci in the liver possibly hemangiomas. Incidentally noted were several nonobstructing left renal stones as well as an IUD. Ultrasound performed that demonstrated two heterogeneous masses in the left lobe of the liver consistent with CT findings, also interpreted as likely hemangiomas.

On examination here in the emergency department patient is tearful, somewhat anxious. Left upper quadrant and epigastric tenderness to palpation. Normal bowel sounds. Patient reports a sensation of tightness in the popliteal fossa of both legs, however neurologic examination is normal. Reports that she "just wants everything figured out." We will obtain screening labs, consideration will be given to additional imaging at this time, although patient does have appropriate followup scheduled already.

07/16/13 14:29
HCG is negative. CBC demonstrates white blood cell count of 12,400 with no left shift. CMP is normal with exception of an ALT of 53. Amylase and lipase normal. Urinalysis demonstrates moderate leukocyte esterase with few bacteria. As patient's last urinalysis appeared contaminated, we will obtain straight catheter urinalysis to rule out urinary tract infection and obtain MRCP today.

07/16/13 16:59
Catheter urinalysis is negative for leukocyte esterase, demonstrates no bacteria. MRCP demonstrates no biliary dilatation or stones. Lesions noted in the liver are not hemangiomas but are probably benign. Patient will be discharged home with

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

outpatient gastroenterology followup in 6 days as scheduled.
Reviewed the Following: Lab, EKG, Imaging
Discussed Investigation, Dx and Tx With: Patient, Family
Risk, Follow-up Discussed With: Patient, Family
Referrals:
Leeloy,Henry K., MD [Primary Care Provider] -
Hartman,William MD, MD [Staff Physician] - (Follow up with Dr. Hartman as scheduled.)
Forms: Return to Work/School
- Disposition

Time of Disposition: 16:56
Disposition: DC
DX: (Primary DX listed 1st):
Abdominal pain
Instructions: General Emergency Department Discharge Instructions, Abdominal Pain (ED)

Signed By: **Calvert, Douglas DO** Date/Time: **07/16/13 1815**
<Electronically signed by Douglas Calvert DO>

CC: Leeloy, Henry K. MD.

FOOTNOTE 26

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MED REC#: HH00507788 NAME: VANHOUTEN,EVERINE A VIP: CONF

ACCOUNT#: HI[redacted] ADMIT DATE: 07/31/13 TIME: 1107 DISCHG DATE:
BIRTHDATE: 0[redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 33 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: KKUALII
FIN CLASS: HMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 17[redacted]ET RELIGION: NONE
K[redacted]
PHONE HM#: ([redacted] PHONE WK#: (8[redacted]

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Budde, James MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: (8[redacted]760
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted]T GUAR EMP PH #: ([redacted]
[redacted] RELATIONSHIP: PATIENT
GUAR PHONE NO: (8[redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 HMSA PO Box 32700,Honolulu,HI 96803 (800)790-4672	[redacted]	690	VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 07/05/13 COA signed? Y If no?

COMMENT:

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010205822**
PCP: **Henry K. Leeloy MD**
ED Provider: **Budde, James MD**
Service Date: **07/31/13**

History of Present Illness

Nursing Note: Agreed With
Chief Complaint: Abdominal Pain
Time Seen by Provider: 07/31/13 11:48
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint Pt here with c/o RUQ pain x 1 month. Pt has an appt with Hartman to schedule an endoscopy.

07/31/13 11:18
This is a 33 year old female with a PMHx of migraines who presents to the ED alone via POV complaining of abdominal pain. Onset March 2013. Pain has been intermittent since March, and the patient was seen in the ED several times since then for abdominal pain. The pain began again today while working and is prominent in the epigastric region and RUQ. Pain is currently severe, sharp, stabbing, and radiates to her back. She took Ibuprofen and zofran at the time without relief. Patient is requesting further pain management at this time. Also notes some intermittent nausea and vomiting. She has an appointment with Dr. Hartman to have an endoscopy scheduled. Patient states she called Dr. Hartman PTA who suggested she come to the ED for pain management. Denies any fever, diarrhea, constipation, rash or any other associated symptoms at this time. Patient is scheduled to see Dr. Hartman this upcoming Monday. Her PCP is Dr. Leeloy and she has seen him for the complaint. She is currently on her menstrual period.

Onset: Weeks
Severity: Moderate
Timing/Duration: Intermittent
Modifying Factors: improves with: Other (none)
Associated Symptoms: None
Allergies/Adverse Reactions:

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

No Known Allergies Allergy (Verified 07/09/13 02:23)

Home Medications:

Medication	Instructions	Recorded	Type
Hydrocodone Bit/ Acetaminophen [Vicodin 5/500 Tablet]	1 each PO Q4HP PRN #20 tablet	07/31/13	Rx
Ondansetron [Zofran Odt(Ondansetron)4Mg *]	4 mg SL Q6HP PRN #10 tablet	07/31/13	Rx
Pantoprazole Sodium [Protonix Tablet]	40 mg PO BID #30 tablet.dr	07/31/13	Rx
Sucralfate [Carafate]	1 gm PO Q4HP PRN #500 ml	07/31/13	Rx

Past Medical History

Past Medical History: Reports: Other (migraines). Denies: Asthma, DM, HTN
Past Surgical History: Cholecystectomy
- Social History

Personal History: Single
Alcohol: Reports: Never
Drugs: Reports: Never
Smoking Status: Never Smoker
Review of Systems

Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Photophobia
Ears/Nose/Mouth/Throat: denies: Epistaxis
Cardiovascular: denies: Palpitations, Orthopnea
Gastrointestinal: Abdominal Pain, Nausea
Genitourinary: denies: Retention
Musculoskeletal: denies: Joint Pain
Integumentary: denies: Bruising
Neurological: denies: Paresthesia
Psychiatric: denies: Anxiety
Hematologic/Lymph: denies: Lymphadenopathy
Physical Exam

Nursing Vital Signs:

Initial Vital Signs

Temperature	36.8 C	07/31/13 11:08
Pulse Rate	90	07/31/13 11:08

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Respiratory Rate	14	07/31/13 11:08
Blood Pressure	119/81	07/31/13 11:08
O2 Sat by Pulse Oximetry	100	07/31/13 11:08

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Normal BS. Not: Tender
Abdominal Tenderness: Epigastric. Not: Present
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry, Other (abdominal surgical scar)
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Mood/Affect, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Purpura, Petechia, Lymphadenopathy
Results/Interpretations
- Laboratory

Result Note:

07/31/13 11:30

9.3	14.5	493H
	42.3	

07/31/13 11:30

135	102	19	99
4.1	25	0.91	

Laboratory Tests

	07/31/13 11:27	07/31/13 11:30	Range/Units
WBC		9.3	(3.8-11.2) 10(9)/L
RBC		4.81	(3.9-5.2) 10(12)/L
Hgb		14.5	(11.6-15.1) g/dL
Hct		42.3	(34.1-44.2) %
MCV		87.9	(80-100) fL
MCH		30.1	(27-33) pg
MCHC		34.3	(32-36) g/dL
RDW		14.3	(11-15) %
Plt Count		493 H	(150-450) 10(9)/L
Neut %		58	(40-70) %
Lymph %		36	(20-45) %
Mono %		4	(4-10) %
Eos %		2	(0-6) %
Baso %		0	(0-2) %
Differential Method		Auto	(())

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Absolute Neutrophils		5.40	(1.4-7.0) 10(9)/L
Absolute Lymphocytes		3.30	(0.7-4.5) 10(9)/L
Absolute Monocytes		0.40	(0.1-1.0) 10(9)/L
Absolute Eosinophils		0.10	(0-0.6) 10(9)/L
Absolute Basophils		0	(0-0.2) 10(9)/L
Sodium		135	(133-145) mmol/L
Potassium		4.1	(3.3-5.1) mmol/L
Chloride		102	(96-108) mmol/L
Carbon Dioxide		25	(21-31) mmol/L
Anion Gap		8	(4-16)
BUN		19	(8-24) mg/dL
Creatinine		0.91	(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)		>60	(>59)
Est GFR (MDRD) Af Amer		>60	(>59)
Glucose		99	(70-99) mg/dL
Calcium		9.4	(8.6-10.3) mg/dL
Total Bilirubin		0.7	(0-1.2) mg/dL
AST		71 H	(0-31) U/L
ALT		50 H	(0-31) U/L
Alkaline Phosphatase		72	(34-104) U/L
Total Protein		8.0	(5.9-8.4) g/dL
Albumin		4.9	(4.0-5.1) g/dL
Globulin		3.1	(2.0-3.6) g/dL
Albumin/Globulin Ratio		1.6	(1.2-2.3)
Lipase		35	(4-58) U/L
Urine Color	Yellow		(())
Urine Appearance	Sl hazy		(())
Urine pH	6.5		(5.0-7.5)
Ur Specific Gravity	1.025		(1.005-1.03)
Urine Protein	Negative		(NEG) mg/dL
Urine Glucose (UA)	Negative		(NEG) mg/dL
Urine Ketones	Negative		(NEG) mg/dL
Urine Blood	Negative		(NEG)
Urine Nitrate	Negative		(NEG)
Urine Bilirubin	Negative		(NEG)
Urine Urobilinogen	0.2		(0.2-1.0) EU/dL
Ur Leukocyte Esterase	Negative		(NEG)
Urine RBC	0-2		(0-2) /hpf
Urine WBC	2-5		(0-5) /hpf
Ur Squamous Epith Cells	Mod		(()) /lpf
Amorphous Crystals	Few		(()) /lpf
Urine Bacteria	Few H		(NONE) /hpf
Urine Mucus	Mod		(()) /lpf
Ur Culture Indicated?	Reflex c/s not done.		(CSND)
Urine HCG, Qual	Negative		(())

Update
- Patient Update

Status on patient:

Pg 4 of 6
Physician Documentation 0731-0067

FOOTNOTE 29

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010207070**
PCP: **Henry K. Leeloy MD**
ED Provider: **Morrison, James S MD**
Service Date: **08/07/13**

<Sarubbi,Jo Ann MD - Last Filed: 08/10/13 17:17>

History of Present Illness
Nursing Note: Agreed With
Chief Complaint: Nausea/vomiting
Stated Complaint: vomiting post scope
Time Seen by Provider: 08/07/13 23:04
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint	pt arrives via POV with c\o emesis
since being	scoped this morning by MD Hartman.
states that	she has been vomiting and dry
heaving since post	procedure, and was sent home with
zofran with	no relief. left facility at 1600.
states she was	being scoped for gallstones.

08/07/13 23:40
This is a 33 year old female pt of Dr. Leeloy with a PMHx of migraines who arrives to the ED via POV with complaints of nausea and vomiting. Pt states that she has been complaining of abdominal pain and vomiting since March 2013. Pt has been seen in the ED on multiple visits for complaints of the same with negative workups. Pt states that she was being seen by her GI doctor, Dr. Hartman, for ERCP with normal results, and was doing well until she started to rouse after procedural sedation where she had multiple episodes of nausea and vomiting. Pt states that she was sent home from Dr. Hartman's office with zofran without relief.

Onset: Hours
Timing/Duration: Intermittent (episodes)
Associated Symptoms: denies: Fever/Chills
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 08/10/13 10:25)

Name: **VANHOUTEN,EVERINE A**
MR#: **HM00507788**
DOB: [redacted]

Home Medications:

Medication	Instructions	Recorded	Type
Ibuprofen [Motrin Tablet]	800 mg PO DAILYP PRN	08/06/13	History
Multivitamin [Multi Vitamin Daily]	1 each PO DAILY	08/06/13	History
Bisacodyl [Dulcolax Tablet]	5 mg PO DAILYP PRN #30 tablet	08/13/13	Rx
Cefuroxime Axetil [Cefuroxime 500Mg]	500 mg PO BID #14 tablet	08/13/13	Rx
Docusate Sodium [Colace Capsule]	100 mg PO BIDP PRN #60 capsule	08/13/13	Rx
Magnesium Chloride [Mag64]	64 mg PO HS #30 tablet.sa	08/13/13	Rx
Omeprazole [Prilosec Capsule]	40 mg PO DAILY #30 capsule	08/13/13	Rx
Ondansetron [Zofran Tablet]	4 mg PO Q4HP PRN #30 tablet	08/13/13	Rx
Tramadol HCl [Ultram Tablet]	50 mg PO Q4HP PRN #30 tablet	08/13/13	Rx
Venlafaxine HCl [Effexor Xr 75Mg]	75 mg PO HS #30 cap	08/13/13	Rx

Past Medical History
Past Medical History: Reports: Other (migraines). Denies: Asthma, DM, HTN
Past Surgical History: Cholecystectomy
Last Menstrual Period: 1 month
Vaccination Hx: Yes: UTD

- Social History
Personal History: Other (unaccompanied at bedside)
Alcohol: Reports: Never
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems
Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Pain, Trauma
Ears/Nose/Mouth/Throat: denies: Earache, Rhinorrhea
Cardiovascular: denies: Chest Pain
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea, Vomiting
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: denies: Back Pain, Neck Pain
Integumentary: denies: Rash, Bruising
Neurological: denies: Headache, Syncope
Allergic/Immunologic: denies: Food Allergy, Drug Allergy, Environmental Allergy, Immunocompromised, Other

Physical Exam
Nursing Vital Signs:

Initial Vital Signs

Temperature	97 F L	08/07/13 22:49
Pulse Rate	119 H	08/07/13 22:49
Respiratory Rate	20	08/07/13 22:49
Blood Pressure	130/74	08/07/13 22:49

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

02 Sat by Pulse Oximetry	98	08/07/13 22:49

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam, Nml Thyroid. No: Nodes, JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress, CW Tenderness to Palp, Wheezing
Gastrointestinal: Soft, Tender, Decr BS
Abdominal Tenderness: Present, RUQ (toward the epigastric region). Not: Rebound, Voluntary Guarding
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Age Behavior, Nml Mood/Affect, Alert

Results/Interpretations

- Laboratory
Result Note:

08/07/13 23:09

14.8H | 12.9 / 38.6 | 406

08/07/13 23:09

135 | 103 | 15
4.2 | 23 | 0.85
142H

Laboratory Tests

	08/07/13 23:09	Range/Units
WBC	14.8 H	(3.8-11.2) 10(9)/L
RBC	4.36	(3.9-5.2) 10(12)/L
Hgb	12.9	(11.6-15.1) g/dL
Hct	38.6	(34.1-44.2) %
MCV	88.4	(80-100) fL
MCH	29.7	(27-33) pg
MCHC	33.6	(32-36) g/dL
RDW	13.4	(11-15) %
Plt Count	406	(150-450) 10(9)/L
Neut %	87 H	(40-70) %
Lymph %	10 L	(20-45) %
Mono %	3 L	(4-10) %
Eos %	0	(0-6) %
Baso %	0	(0-2) %
Differential Method	Auto	(())
Absolute Neutrophils	12.90 H	(1.4-7.0) 10(9)/L
Absolute Lymphocytes	1.50	(0.7-4.5) 10(9)/L
Absolute Monocytes	0.40	(0.1-1.0) 10(9)/L
Absolute Eosinophils	0	(0-0.6) 10(9)/L

Name: VANHOUTEN,EVERINE A
MR #: HM00507788
DOB: [redacted]

Absolute Basophils	0	(0-0.2) 10(9)/L
Sodium	135	(133-145) mmol/L
Potassium	4.2	(3.3-5.1) mmol/L
Chloride	103	(96-108) mmol/L
Carbon Dioxide	23	(21-31) mmol/L
Anion Gap	9	(4-16)
BUN	15	(8-24) mg/dL
Creatinine	0.85	(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60	(>59)
Est GFR (MDRD) Af Amer	>60	(>59)
Glucose	142 H	(70-99) mg/dL
Calcium	9.0	(8.6-10.3) mg/dL
Total Bilirubin	0.8	(0-1.2) mg/dL
AST	110 H	(0-31) U/L
ALT	144 H	(0-31) U/L
Alkaline Phosphatase	83	(34-104) U/L
Total Protein	7.0	(5.9-8.4) g/dL
Albumin	4.4	(4.0-5.1) g/dL
Globulin	2.6	(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7	(1.2-2.3)
Amylase	74	(28-100) U/L
Lipase	20	(4-58) U/L

Update

- Patient Update
Status on patient:
Charting performed by ED scribe Emily Brinkman for Dr. Sarubbi.

08/08/13 01:40
The patient had an ERCP done today, the operative report states that the exam is normal. The patient's symptoms resolved with medication. Her symptoms tonight according to the patient with the same symptoms. She was having the testing for

Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Diphenhydramine HCl Benadryl Injection	25 mg IV ONCE ONE	08/08/13 11:45 08/08/13 11:46	08/08/13 11:45 25 mg Administration
Hydromorphone HCl Dilaudid Injection	1 mg IVP ONCE ONE	08/08/13 01:11 08/08/13 01:12	08/08/13 01:19 1 mg Administration
Hydromorphone HCl Dilaudid Injection	1 mg IM ONCE ONE	08/08/13 07:03 08/08/13 07:04	08/08/13 07:03 1 mg Administration
Sodium Chloride Sodium Chloride 0.9% Bag	1,000 mls @ 150 mls/hr IV	08/07/13 23:36 08/08/13 06:15	08/07/13 23:39 150 mls/hr

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

	.Q6H40M ONE		Administration
Lorazepam Ativan Injection	1 mg IV ONCE ONE	08/07/13 23:36 08/07/13 23:37	08/07/13 23:39 1 mg Administration
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	08/07/13 23:37 08/07/13 23:38	08/07/13 23:37 10 mg Administration
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	08/07/13 23:37 08/07/13 23:38	08/07/13 23:39 Not Given
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	08/07/13 23:07 08/07/13 23:08	08/07/13 23:07 4 mg Administration
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	08/07/13 23:36 08/07/13 23:37	08/07/13 23:39 4 mg Administration
Ondansetron HCl Zofran Odt Tablet	4 mg PO ONCE ONE	08/08/13 09:46 08/08/13 09:47	08/08/13 09:46 4 mg Administration
Prochlorperazine Edisylate Compazine Injection	10 mg IV ONCE ONE	08/08/13 04:09 08/08/13 04:10	08/08/13 04:09 10 mg Administration

Medical Decision Making/Dispo
MDM Note/Critical Care Macro:

Patient presents to the emergency department with abdominal pain. After history, physical exam, and diagnostic evaluation, the etiology for their pain is unclear.the patien has been having these same symtoms fro months with no dx. she underwent a ERCP today which the perliminary report is negative. In the emergency department they received [NS IV,dilaudid, and Zofran IV]. Laboratory data was nondiagnostic. White blood cell count was slightly elevated.. On serial exam their pain improved. At this point it is unclear exactly the etiology of the pt's pain; but I think they are at low risk for significant abdominal pathology based on serial exams and our ED evaluation. Patient is advised to have a followup with their primary care physician tomorrow for a recheck and repeat abdominal exam. They were advised to return to the emergency department if significant pain, fevers, not tolerating oral food or fluid, or new complaints
Reviewed the Following: Lab
Discussed Investigation, Dx and Tx With: Patient
Risk, Follow-up Discussed With: Patient
Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - 6 to 10 Days
Hartman,William MD, MD [Staff Physician] - 3 to 5 Days

- Disposition
Time of Disposition: 06:26
Disposition: DC
DX: (Primary DX listed 1st):
Abdominal pain, Persistent recurrent vomiting
Condition: Stable
Instructions: ABDOMINAL PAIN, General Emergency Department Discharge Instructions
Custom Instructions:
Continue regular medications, take Zofran every 6 hours. Follow up with Dr. Hartman on monday.

<Morrison,James S MD - Last Filed: 08/13/13 16:24>
Pg 5 of 6
Physician Documentation 0807-0189

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Results/Interpretations

- CT Scan
** CT # 1
CT Notes:

08/08/13 12:58
HHSC\ewyatt, Wyatt, Dr. Eric MD - 8/8/2013 12:38:38 PM
Small gas bubble in the liver consistent with recent ERCP and sphincterotomy. Proximal to the gas bubble is a curvilinear area of decreased density suspicious for a very focal cholangitis. It measures proximately 3.5 cm in length and 5 mm in width. Status post cholecystectomy. The previous CC and enhancing masses in the liver are no longer visualized. There are only seen on the very early arterial images. Today's scan is more delayed. Continued surveillance is recommended as per the MRI report. No bowel obstruction. No free intraperitoneal gas. No other evidence for acute disease.

Signed By: **Sarubbi, Jo Ann MD** Date/Time: **08/10/13 1757**
<Electronically signed by Jo Ann Sarubbi MD>
08/13/13 1626
<Electronically signed by James S Morrison MD>

CC: Leeloy, Henry K. MD.